Children with Special Health Needs Program
REFERRAL FOR SERVICE

Date _____

Child's Name_____
LAST FIRST MIDDLE

Date of Birth _____ **Sex/Gender:** **Male** _____ **Female** _____

Address _____ **Home Phone** _____

Mailing Address (if different from above) _____

Mother's Name _____ **Work/Cell Phone** _____
LAST FIRST M.I.

Father's Name _____ **Work/Cell Phone** _____
LAST FIRST M.I.

Legal Guardian/Other Contact Person _____
LAST FIRST M.I.

Relationship to Child _____ **Home Phone** _____ **Work/Cell** Phone _____

Child's Health Insurance Plan _____ **Member Number** _____
IF QUEST, SPECIFY PLAN

Physician/Primary Care Provider _____ **Phone** _____

Dentist/Dental Provider _____ **Phone** _____

Reason for Referral _____

_____

_____

_____

_____

Significant Information (i.e. hospitalizations, conditions/diagnoses, discharge date, evaluations conducted)

_____

_____

_____

_____

Other Agencies Involved with Contact Numbers (if additional, please attach or use other side of referral)

1. _____ _____ **4.** _____ _____

2. _____ _____ **5.** _____ _____

3. _____ _____ **6.** _____ _____

Referred By _____ _____ _____
NAME **TITLE** **AGENCY** **PHONE** **FAX**

PLEASE MAIL OR FAX REFERRAL TO (808)733-9068

Call the numbers listed below for more information

Children with Special Health Needs Program
State of Hawaii / Department of Health
741 Sunset Avenue ▪ Honolulu, Hawaii 96816

Oahu 733-9066
Kona 322-4880
Hilo 974-4288

Maui 984-2130
Kauai 241-3376
Molokai & Lanai 733-9066 *(call collect)*